State Corporation Commission
Bureau of Insurance
External Appeals
P.O. Box 1157
Richmond, VA 23218
(804) 371-9913

IMPORTANT TERMS AND DEFINITIONS

"Appellant" - means (i) the covered person; (ii) the covered person's parent, guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person, if the covered person is a minor; (iii) the covered person's spouse, parent, committee, legal guardian, or other individual authorized by law to act on behalf of the covered person, if the covered person is not a minor but is incompetent or incapacitated; or (iv) the covered person's treating health care provider acting with the consent of the covered person, the covered person's parent, guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person, if the covered person is a minor, or the covered person's spouse, parent, committee, legal guardian or other individual authorized by law to act on behalf of the covered person, if the covered person is not a minor but is incompetent or incapacitated.

"Covered person" - means an individual, whether a policyholder, subscriber, enrollee, covered dependent, or a member of a managed care health insurance plan, who is entitled to health care services or benefits provided, arranged for, paid for, or reimbursed pursuant to a managed care health insurance plan as defined in and subject to regulation under Chapter 58 (§ 38.2-5800 et seq.) of Title 38.2 of the Code of Virginia, when such coverage is provided under a contract issued in this Commonwealth.

"Cost of Service" - the total amount paid by the covered person for a rendered service or the assumed liability for that service by the covered person for a rendered service. The law requires that in order for an appeal of a final adverse decision to occur, the actual cost to the covered person of the service if the final adverse decision is not reversed must exceed $300.

"Emergency Medical Condition" - the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, the absence of which would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. "Emergency medical condition" also means a health condition or illness that if not treated within the time frame allotted for a standard review will result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the covered person's health in serious jeopardy. "Emergency medical condition" also means a health condition that would be terminal without the requested treatment as determined by the person's treating health care provider.

"Expedited Review" - a review of a final adverse decision that is provided in an urgent manner due to the fact that the covered person has an emergency medical condition.

"Final Adverse Decision" - means a utilization review determination: (i) declining to grant an expedited review in a situation involving an alleged emergency medical condition; (ii) declining to provide coverage or services for an alleged emergency medical condition after granting an expedited review; or (iii) denying benefits or coverage, and concerning which all internal appeals available to the covered person pursuant to Title 32.1 of the Code of Virginia have been exhausted. In other words, and except in emergency situations, it is the final decision of the plan after the internal appeal process has been exhausted.

"Impartial Health Entity" - an organization selected by the Bureau of Insurance that performs, under contract with the Bureau of Insurance, reviews of final adverse decisions. The Bureau of Insurance is not an impartial health entity.

"Managed Care Health Insurance Plan" or **"MCHIP"** - an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange and pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services and requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with, or employed by the health carrier.